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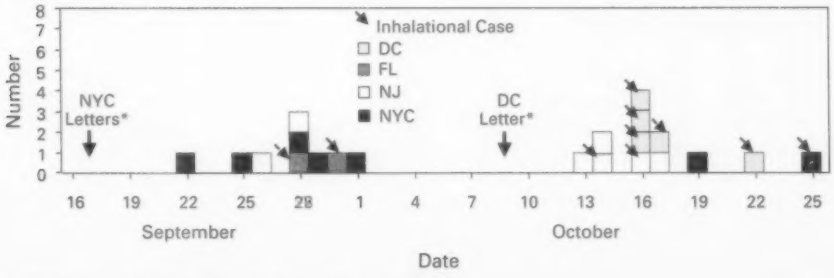
Update: Investigation of Bioterrorism-Related Anthrax and Interim Guidelines for Clinical Evaluation of Persons with Possible Anthrax

Since October 3, 2001, CDC and state and local public health authorities have been investigating cases of bioterrorism-related anthrax. This report updates findings as of October 31, and includes interim guidelines for the clinical evaluation of persons with possible anthrax. A total of 21 cases (16 confirmed and five suspected) of bioterrorism-related anthrax have been reported among persons who worked in the District of Columbia, Florida, New Jersey, and New York City (Figure 1). Until the source of these intentional exposures is eliminated, clinicians and laboratorians should be alert for clinical evidence of *Bacillus anthracis* infection. Epidemiologic investigation of these cases and surveillance to detect new cases of bioterrorism-associated anthrax continues.

New York

To date, the investigations in New York City have identified one confirmed inhalational case and six (three confirmed and three suspected) cutaneous anthrax cases; the confirmed inhalational and one suspected cutaneous case have been identified since the last report (*1*). The six cutaneous cases were associated with four media companies (A–D); the most recent suspected cutaneous case is associated with company D. The most

FIGURE 1. Number of bioterrorism-related anthrax cases, by date of onset and work location — District of Columbia (DC), Florida (FL), New Jersey (NJ), and New York City (NYC), September 16–October 25, 2001



* Postmarked date of known contaminated letters.

recent confirmed inhalational case is not directly associated with any media company or with mail handling. No cases among postal workers have been identified.

The most recent suspected cutaneous case occurred in a 34-year-old man who worked in the mail room of company D who might have handled a letter postmarked September 18, which the patient handled during October 12–15 and subsequently was found to contain *B. anthracis* (*1*). On October 19, the patient noted a small, erythematous pruritic papule on his left forearm that later developed a small vesicle. On October 21, he started ciprofloxacin. By October 22, an eschar had developed, increased in size, and over the next several days was surrounded by erythema, edema, and induration. A biopsy was positive for *B. anthracis* by immunohistochemical (IHC) staining.

The inhalational anthrax case occurred in a 61-year-old woman who worked in the stockroom of a hospital in Manhattan. The patient became ill on October 25 with malaise and myalgias. During the next several days, she had shortness of breath, chest discomfort, and a productive cough with blood-tinged sputum. She reported no fever, chills, or night sweats. She presented to an emergency department on October 28 in respiratory distress. Her temperature was 102 F (39 C), and she was admitted to the intensive care unit and required mechanical ventilation. Initial chest radiograph revealed pulmonary venous congestion and bilateral pleural effusions; a chest computerized tomography (CT) scan revealed a widened mediastinum and bilateral pleural effusions. An echocardiogram indicated a small pericardial effusion. She was empirically treated with levofloxacin, rifampin, and clindamycin. Blood cultures grew *B. anthracis* less than 24 hours after admission. Her pleural effusion revealed hemorrhagic fluid and *B. anthracis*. The patient died on October 31.

New Jersey

To date, investigations in New Jersey and Pennsylvania have identified seven (five confirmed and two suspected) anthrax cases. Since the last report (*1*), cutaneous disease was confirmed in two patients, and inhalational anthrax was confirmed in two patients, one of whom was previously classified as a suspected case-patient. Five patients worked in New Jersey at one of two postal facilities. Although no specific contaminated letter was implicated in these cases, contaminated letters destined for both New York City and the District of Columbia passed through at least one of the postal facilities in New Jersey.

Inhalational anthrax was confirmed in a 56-year-old female postal worker who initially was classified as a suspected case-patient (*1*). Her pleural fluid was positive for *B. anthracis* by polymerase chain reaction (PCR) and a pleural biopsy was positive for *B. anthracis* by IHC staining.

On October 13, a 54-year-old Delaware resident who worked as a mail sorter at a New Jersey postal processing and distributing center developed a painless lesion on the dorsum of his left hand. The lesion began as an erythematous "knot" several millimeters in size that developed a crusted scale during the next few days. No associated edema, eschar, or lymphadenopathy was observed. The patient had elevated levels of serum antibody (IgG) to the protective antigen component of the anthrax toxin using enzyme-linked immunosorbant assay.

On October 15, a 43-year-old female postal worker who worked at a facility in which anthrax cases have been documented developed fever, headache, chills, and shortness of breath. She was treated with levofloxacin, but her symptoms progressed and she was admitted to a hospital on October 18. A chest radiograph indicated a right perihilar

infiltrate and a small pleural effusion. She was started on multidrug therapy, including ciprofloxacin, which was changed to azithromycin after 24 hours. On admission, she was febrile and tachycardic. She had an elevated white blood cell (WBC) count of 11,000 with 14% bands. A CT scan on October 19 showed a right pleural effusion, perihilar consolidation, and mediastinal adenopathy. She subsequently had two thoracenteses that produced serosanguinous pleural fluid and a bronchoscopy that showed grossly edematous bronchi. Both pleural fluid and bronchial biopsy were positive for *B. anthracis* by IHC stain.

On October 17, a 51-year-old woman developed a large pimple on her forehead with erythema and swelling. On October 18, the lesion enlarged, was slightly painful, nonpruritic, and drained a small amount of yellowish fluid. She sought medical care, cervical and preauricular lymphadenopathy was noted on physical examination, and she was treated with ciprofloxacin. The lesion progressed and ulcerated. On October 22, she presented to an emergency department and was admitted with a diagnosis of cellulitis. On admission, she was afebrile with normal vital signs and had a swollen right face and eyelid and enlarged right anterior cervical nodes. Intravenous ciprofloxacin for cutaneous anthrax was started. On October 24, the ulcer was biopsied and debrided. Biopsy specimens were positive for *B. anthracis* by PCR and IHC. The patient improved and was discharged on October 27 on oral ciprofloxacin. The patient worked as a bookkeeper and reported receiving no unusual or powder-containing mail at home or work. She had made no visits to any post offices in several months.

District of Columbia

To date, investigations in the District of Columbia, Maryland, and Virginia have confirmed inhalational anthrax in four persons who worked at one postal facility in the District of Columbia. An additional case of inhalational anthrax has been confirmed in a 59-year-old postal worker in a U.S. State Department mail sorting facility that receives mail from the District of Columbia postal facility associated with the previous four cases. The patient presented to an emergency department on October 24 with temperature of 100.8 F (38 C), sweats, myalgia, chest discomfort, mild cough, nausea, vomiting, diarrhea, and abdominal pain. A chest radiograph initially was interpreted as normal but on further review indicated mediastinal widening. A CT scan showed mediastinal lymphadenopathy, hemorrhagic mediastinitis, small bilateral pleural effusions, and a small pericardial effusion. Blood cultures grew *B. anthracis*. The patient is receiving ciprofloxacin, rifampin, and penicillin.

Florida

To date, the investigation in Florida has identified two confirmed inhalational cases. No new cases have been identified since the last report (*1*).

Clinical Presentation of Inhalational and Cutaneous Cases

Inhalational anthrax

To date, CDC has identified 10 patients with confirmed or suspected inhalational anthrax associated with bioterrorism. All but the most recent patients were postal workers (six), mail handlers or sorters (two), or a journalist who were known to or believed to have processed, handled, or received letters containing *B. anthracis* spores. The hospital employee with inhalational anthrax did not process mail but might have carried mail to other parts of the facility. Preliminary environmental testing of the patient's work area and home was negative for *B. anthracis*. The investigation is ongoing.

Update: Investigation of Anthrax — Continued

The median age of the 10 patients with inhalational anthrax was 56 years (range: 43–73 years); seven were men. The incubation period from the time of exposure to onset of symptoms when known (seven) was 7 days (range: 5–11 days).

The initial illness in these patients was characterized by fever (nine) and/or sweats/chills (six) (Figure 2). Severe fatigue or malaise was present in eight and minimal or nonproductive cough in nine, including one with blood-tinged sputum. Eight patients reported chest discomfort or pleuritic pain. Abdominal pain or nausea or vomiting occurred in five, and five reported chest heaviness. Other symptoms included shortness of breath (seven), headache (five), myalgias (four), and sore throat (two).

On initial presentation, total WBC count was normal or slightly elevated (7.5–13.3 x 10^3/cumm); however, elevation in the percentage of neutrophils or band forms was frequently noted. None of the patients had a low WBC count or lymphocytosis when initially evaluated. Chest radiograph was abnormal in all patients, but in two an initial reading was interpreted as within normal limits. Mediastinal changes including mediastinal widening, paratracheal fullness, hilar fullness, and mediastinal lymphadenopathy were noted in all eight patients who had CT scans. Mediastinal widening may be subtle, and careful review of the chest radiograph by a radiologist may be necessary. Pleural effusions were present in seven patients and were a feature of the two patients who did not have mediastinal changes on chest radiograph or did not have a CT scan. Pleural effusions often were large and hemorrhagic, reaccumulated, and required repeated thoracentesis or chest tubes. Pulmonary infiltrates were observed in four patients and were multilobar in three. Blood cultures grew *B. anthracis* in seven patients and in all who had not received antimicrobials. Diagnosis in the patients with negative cultures was confirmed by bronchial or pleural biopsy and specific IHC staining, by PCR of material from a sterile site, or by a fourfold rise in IgG to the protective antigen.

To date, six of 10 patients with inhalational anthrax have survived. Among those whose condition was recognized early, all remain alive and two have been discharged from the hospital. Prompt recognition of the early features of inhalational anthrax is important in settings of known or suspected exposure.

Cutaneous anthrax

Eleven patients with cutaneous anthrax have been identified in the current outbreak. Patients with cutaneous anthrax were mail handlers or sorters (four), employees of or visitors to media companies (six), and one bookkeeper. The mean incubation period for cutaneous anthrax was 5 days (range: 1–10 days) based on estimates from the postmark of letters and assumptions of dates of exposures with known positive letters or suspect letters (Figure 3).

Lesions occurred on the forearm, neck, chest, and fingers (two). Lesions were painless but accompanied by a tingling sensation or pruritis. Diagnosis was established by biopsy or culture.

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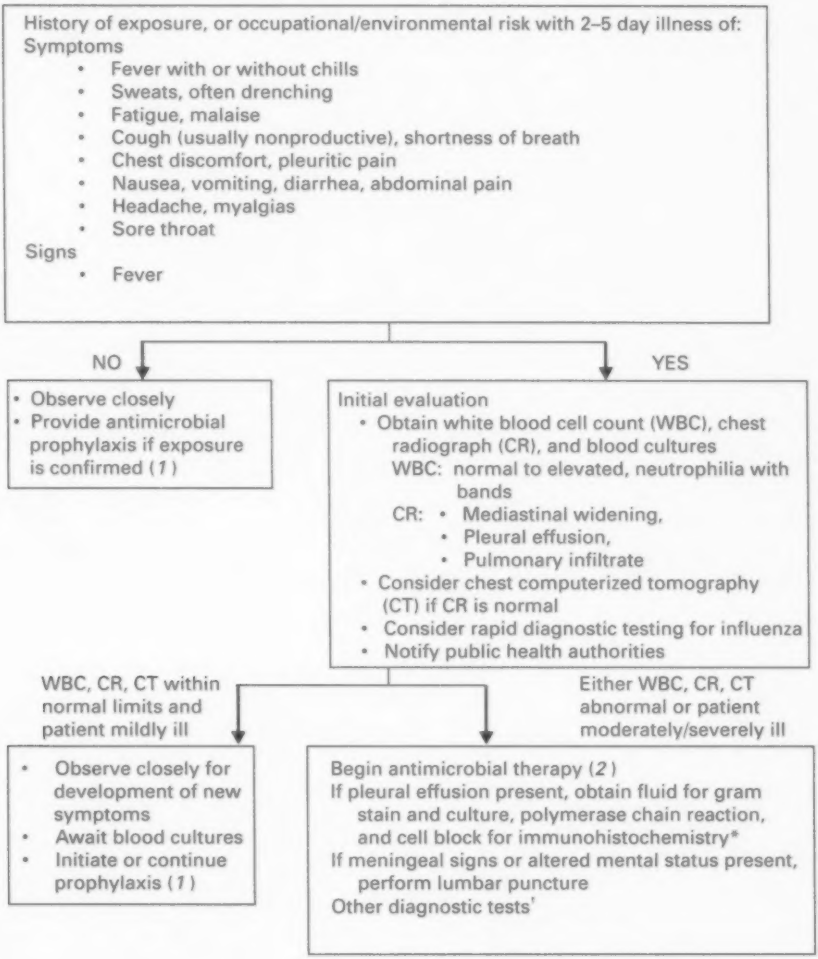
Update: Investigation of Anthrax — Continued

FIGURE 2. Clinical evaluation of persons with possible inhalational anthrax



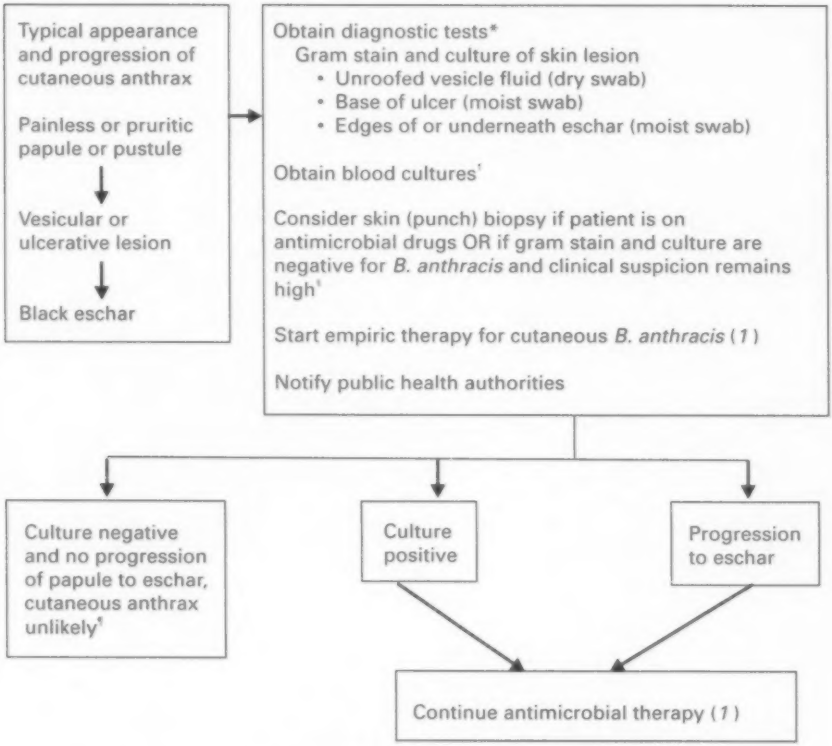
* Available through CDC or LRN. Cell block obtained by centrifugation of pleural fluid.
† Serologic testing available at CDC may be an additional diagnostic technique.

References

1. CDC. Update: investigation of anthrax associated with intentional exposure and interim public health guidelines, October 2001. MMWR 2001;50:889–93.
2. CDC. Update: investigation of bioterrorism-related anthrax and interim guidelines for exposure management and antimicrobial therapy, October 2001. MMWR 2001;50:909–19.

Update: Investigation of Anthrax — Continued

FIGURE 3. Clinical evaluation of persons with possible cutaneous anthrax



* Serologic testing available at CDC may be an additional diagnostic technique for confirmation of cases of cutaneous anthrax.

† If blood cultures are positive for *B. anthracis*, treat with antimicrobials as for inhalational anthrax (*1*).

§ Punch biopsy should be submitted in formalin to CDC. Polymerase chain reaction can also be done on formalin-fixed specimen. Gram stain and culture are frequently negative for *B. anthracis* after initiation of antimicrobials.

¶ Continued antimicrobial prophylaxis for inhalational anthrax for 60 days if aerosol exposure to *B. anthracis* is known or suspected (*2*).

Reference

1. CDC. Update: investigation of bioterrorism-related anthrax and interim guidelines for exposure management and antimicrobial therapy, October 2001. MMWR 2001;50:909–19.
2. CDC. Update: investigation of anthrax associated with intentional exposure and interim public health guidelines, October 2001. MMWR 2001;50:889–93.

Update: Investigation of Anthrax — Continued

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Editorial Note: Since the last report (*1*), six new anthrax cases have been reported. Three of these cases have occupational exposures similar to previously reported cases (*1*). A fourth case occurred in a mail handler at a facility not previously linked to cases but that receives mail from a facility at which cases have occurred previously. Two new cases have no discernable epidemiologic link with anthrax cases previously reported or sites that are associated with known cases. These new cases suggest that anthrax exposure has occurred or is continuing to occur through means that cannot be ascribed to known contaminated letters or the paths these letters took through the mail service. The public health response to these new anthrax cases will evolve based on ongoing epidemiologic and criminal investigations.

Because exposures are being intentionally perpetrated, public health authorities must be vigilant for the appearance of new cases in previously unaffected populations. Prompt data sharing between law enforcement and public health authorities is essential.

Since September 11, 2001, state and local health departments have been responding to many reports of potential bioterrorist threats including letters containing powder, suspicious packages, and potential dispersal devices. During September 11–October 17, 40 state and territorial health officials who responded to a CDC telephone survey estimated that 7,000 reports had been received at their health departments, approximately 4,800 required phone follow-up, and 1,050 reports led to testing of suspicious materials at a public health laboratory (CDC, unpublished data, 2001). In comparison, the number of anthrax threats reported to federal authorities during 1996–2000 did not exceed 180 reported threats per year (Federal Bureau of Investigation, unpublished data, 2001). Therefore, although only four areas have identified cases of bioterrorism-associated anthrax, health departments throughout the nation are responding to public concerns, bioterrorism hoaxes, and threats.

CDC is working with state and local health departments and the U.S. Postal Service to develop standardized guidelines for identifying populations that should receive antimicrobial prophylaxis for prevention of inhalational anthrax. Current challenges include identifying factors that promote the aeresolization of *B. anthracis* in mail-handling facilities and assessing the risk for anthrax in environments contaminated with *B. anthracis* spores. Safe levels of *B. anthracis* spore contamination in occupational settings must be defined to determine the need for clean-up of contaminated facilities. The current antimicrobial prophylaxis recommendations address the prevention of inhalational anthrax, but CDC also is evaluating measures to prevent cutaneous anthrax.

Postexposure prophylaxis with a recommended antimicrobial agent for the prescribed period of time can prevent inhalational anthrax. In the case of a known contaminated letter sent to the office of a U.S. Senator, antimicrobial prophylaxis was administered to persons from the area of exposure and first-responders to the incident (*1*). To date, there have been no cases of anthrax, even among those who had the greatest exposure. Antimicrobial prophylaxis had been recommended for the U.S. State Department mail handler with anthrax, but the worker had not started treatment before the onset of illness. Public health response must include prompt initiation of prophylaxis for exposed persons and systems to promote adherence to a full 60-day regimen.

Update: Investigation of Anthrax — Continued

Previous guidelines recommended ciprofloxacin for antimicrobial prophylaxis until antimicrobial susceptibility test data was available (*3*). Isolates involved in the current bioterrorism attacks have been susceptible to ciprofloxacin, doxycycline, and several other antimicrobial agents. Considerations for choosing an antimicrobial agent include effectiveness, resistance, side effects, and cost. No evidence demonstrates that ciprofloxacin is more or less effective than doxycycline for antimicrobial prophylaxis to *B. anthracis*. Widespread use of any antimicrobial will promote resistance. Many common pathogens are already resistant to tetracyclines such as doxycycline. However, fluoroquinolone resistance is not yet common in these same organisms. To preserve the effectiveness of fluoroquinolone against other infections, use of doxycycline for prevention of *B. anthracis* infection among populations at risk may be preferable. However, the selection of the antimicrobial agent for an individual patient should be based on side-effect profiles, history of reactions, and the clinical setting.

CDC and state and local public health agencies continue to mobilize epidemiologic, laboratory, and other staff to identify and investigate acts of bioterrorism. Cases of bioterrorism-associated anthrax continue to occur and new risk populations may be identified. Until the cause of these acts are removed, public health authorities and clinicians should remain alert for cases of anthrax.

References

1. CDC. Update: investigation of bioterrorism-related anthrax and interim guidelines for exposure management and antimicrobial therapy. MMWR 2001;50:909–19.
2. CDC. Update: investigation of anthrax associated with intentional exposure and interim public health guidelines. MMWR 2001;50:889–93.
3. Inglesby TV, Henderson DA, Bartlett JG, et al. Anthrax as a biological weapon: medical and public health management. JAMA 1999;281:1735–45.

Major Cardiovascular Disease (CVD) During 1997–1999 and Major CVD Hospital Discharge Rates in 1997 Among Women with Diabetes — United States

Cardiovascular disease (CVD) is the leading cause of death among all women (*1*) and the risk for death from CVD among women with diabetes is two to four times higher than that for women without diabetes (*2*). The excess risk for death as the result of CVD among persons with diabetes is better understood than the excess risk for CVD morbidity (*2*). To estimate national CVD prevalence and CVD hospital use among women with diabetes, CDC and the Agency for Health Care Research and Quality (AHRQ) analyzed data from the 1997–1999 National Health Interview Survey (NHIS) and the 1997 Nationwide Inpatient Sample (NIS). Findings indicate that the age-adjusted prevalence of major CVD for women with diabetes is twice that for women without diabetes and that the age-adjusted major CVD hospital discharge rate for women with diabetes is almost four times the rate for women without diabetes. These findings underscore the need to reduce risk factors associated with CVD among all women with diabetes through focused public health and clinical efforts.

The prevalence of CVD among women aged ≥18 years by diabetes status was obtained from a 3-year average of the estimates from the 1997–1999 NHIS, an ongoing nationally representative survey providing information on the health of the noninstitutionalized U.S. civilian population. Respondents were asked whether they had

Major Cardiovascular Disease — Continued

ever been told by a doctor or other health-care provider that they had hypertension, coronary heart disease, angina, heart attack, other kinds of heart conditions or heart disease, stroke, or diabetes. Major CVD was defined as one or more positive responses to the six CVD condition questions, and diabetes was defined as a positive response to the diabetes question.

The number of major CVD hospital discharges was estimated from the 1997 NIS, a stratified probability sample of hospitals in 22 states. Discharges from the 22 states represented approximately 60% of all discharges in the United States. Sample data were weighted using the American Hospital Association Annual Survey of Hospitals to approximate discharges from all U.S. acute-care community hospitals. Analysis was restricted to major CVD discharges (e.g., ischemic heart disease, hypertensive disease, rheumatic heart disease, and stroke) having an *International Classification of Disease, Ninth Revision, Clinical Modification* (*ICD-9-CM*) code of 390–448 as the first-listed diagnosis. Diabetes-related discharges were identified as those with an *ICD-9* code of 250 as a secondary diagnosis. Major CVD discharge rates were calculated for the U.S. female population aged ≥18 years with and without diabetes by dividing the number of major CVD discharges estimated from NIS by the estimated number of women with and without diabetes obtained using 1997 NHIS data. Rate ratios and rate differences were calculated for both major CVD prevalence and hospital discharge rates by comparing rates for women with diabetes with those for women without diabetes. SUDAAN was used to calculate all estimates and their standard errors because of the complex sample designs of NIS and NHIS.

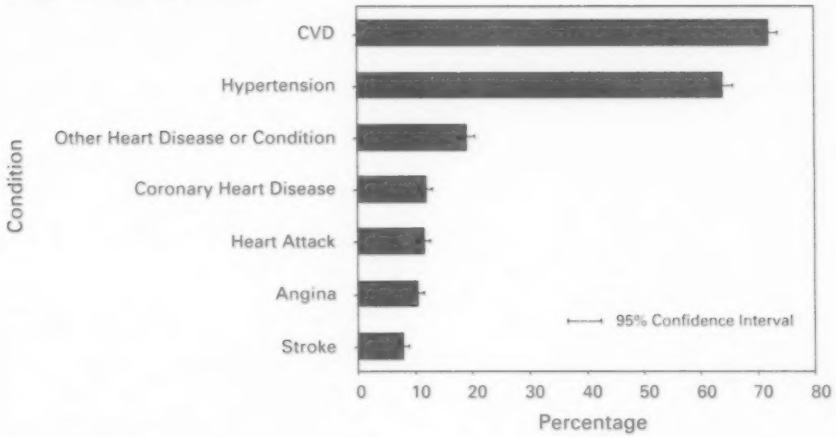
Major CVD rates were age-adjusted to the 2000 U.S. standard population (*3*). Trends were assessed by age for major CVD prevalence and for hospital discharge rates, rate ratios, and rate differences. The difference between age-adjusted major CVD prevalence and hospital discharge rates by diabetes status across all racial/ethnic categories was assessed using z-tests; a t-test in SUDAAN was used to assess the difference in age-adjusted major CVD prevalence and hospital discharge rates by race/ethnicity, comparing non-Hispanic whites, non-Hispanic blacks, and Hispanics. Other racial/ethnic groups were not included because sample size was too small for meaningful analysis.

During 1997–1999, 72% (95% confidence interval [CI]=±1.8%) of all women with diabetes self-reported having major CVD (Figure 1). The most common CVD condition was hypertension (64%; 95% CI=±1.8%) followed by other heart disease or conditions (19%; 95% CI=±1.5%), coronary heart disease (12%; 95% CI=±1.2%), heart attack (11%; 95% CI=±1.3%), angina (10%; 95% CI=±1.1%), and stroke (8%; 95% CI=±1.0%) (Figure 1).

The prevalence of major CVD increased with age for women with diabetes from 40.5% (95% CI=±4.9%) for women aged 18–44 years to 85.1% (95% CI=±3.0%) for women aged ≥75 years ($p<0.0001$) (Table 1). The age-adjusted prevalence of major CVD among women with diabetes was twice that of women without diabetes ($p<0.0001$) (Table 1). Age-adjusted major CVD prevalence for women with diabetes was higher for non-Hispanic blacks (65.2%; 95% CI=±5.3%) than for non-Hispanic whites (55.7%; 95% CI=±3.7%) ($p=0.004$) or Hispanics (56.6%; 95% CI=±6.5%) ($p=0.05$). The rate ratio of major CVD in women with diabetes relative to women without diabetes ranged from 3.0 (95% CI=±0.4) for women aged 18–44 years to 1.3 (95% CI=±0.1) for those aged ≥75 years ($p=0.09$). Although rate differences were greatest among women aged 45–64 years and lowest among women aged ≥75 years, no significant trend by age was found ($p=0.27$) (Table 1).

Major Cardiovascular Disease — Continued

FIGURE 1. Prevalence of major cardiovascular disease (CVD) and specific CVD conditions among women with diabetes — National Health Interview Survey, United States, 1997–1999*



* 3-year average.

During 1997, 772,346 of all major CVD hospital discharges (28%) had diabetes as a secondary diagnosis (Table 2). Hospital discharge rates for major CVD among women with diabetes increased from 22.9 per 1,000 (95% CI=±4.5) for the youngest age group to 332.7 per 1,000 (95% CI=±54.3) for the oldest age group (p=0.0004) (Table 2). The age-adjusted major CVD hospital discharge rate for women with diabetes was 3.8 times that of women without diabetes (Table 2). No significant difference was found among racial/ethnic groups for major CVD hospital discharge rates among women with diabetes. The rate ratio comparing major CVD hospital discharges in women with diabetes with those without diabetes decreased with age from 11.8 per 1,000 (95% CI=±2.4) in the youngest age group to 2.4 per 1,000 (95% CI=±0.4) in the oldest (p=0.04). Rate differences increased with age from 20.9 per 1,000 (95% CI=±4.4) in the youngest to 196.5 per 1,000 (95% CI=±55.2) in the oldest (p=0.02) (Table 2).

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Editorial Note: This report indicates that 72% of U.S. women with diabetes self-reported having major CVD. Major CVD prevalence is twice as common and major CVD hospitalizations are nearly four times as common among women with diabetes compared with women without diabetes. These findings are consistent with mortality studies documenting that women with diabetes are at much higher risk for death as a result of major CVD than women without diabetes (*2*).

Clinical trials indicate that antihypertensive treatment (*4*), aspirin use (*5*), and lipid-lowering therapies (*6*) prevent or delay cardiovascular events. Epidemiologic evidence suggests that the risk for major CVD might be reduced through glycemic control (*7*) and the promotion of healthy lifestyles, including weight reduction/obesity prevention,

TABLE 1. Number* and rate† of major cardiovascular disease (CVD) among women with and without diabetes, by age and race/ethnicity — National Health Interview Survey, United States, 1997–1999§

Characteristic	Diabetes			No diabetes			Rate ratio	(95% CI)	Rate difference	(95% CI)
	No.	Rate	(95% CI¶)	No.	Rate	(95% CI)				
Age group (yrs)										
18–44	367,750	40.5	(35.6–45.3)	7,121,007	13.3	(12.8–13.8)	3.0	(2.7–3.4)	27.2	(22.3–32.0)
45–64	1,648,082	72.9	(70.2–75.6)	9,073,706	34.1	(33.2–35.0)	2.1	(2.0–2.2)	38.8	(36.0–41.6)
65–74	1,114,985	81.1	(78.1–84.0)	4,656,932	55.9	(54.3–57.4)	1.5	(1.4–1.5)	25.2	(21.9–28.5)
≥75	865,584	85.1	(82.1–88.1)**	4,945,152	66.2	(64.7–67.6)**	1.3	(1.2–1.3)††	18.9	(15.6–22.2)§§
Unadjusted total	**3,996,401**	**71.8**	**(70.1–73.6)**	**25,796,797**	**26.9**	**(26.4–27.3)**	**2.7**	**(2.6–2.8)**	**45.0**	**(43.1–46.8)**
Age-adjusted total¶¶		**57.4**	**(54.7–60.1)**		**27.6**	**(27.2–28.0)**	**2.1**	**(2.0–2.2)**	**29.8**	**(27.0–32.5)**
Race/Ethnicity¶¶										
White, non-Hispanic	2,681,463	55.7	(52.0–59.4)	20,052,115	27.1	(26.6–27.6)	2.1	(1.9–2.2)	28.6	(24.9–32.3)
Black, non-Hispanic	814,748	65.2	(60.0–70.5)	3,463,197	36.4	(35.2–37.6)	1.8	(1.6–2.0)	28.9	(23.5–34.3)
Hispanic	403,153	56.6	(50.2–63.1)	1,671,038	24.1	(23.0–25.3)	2.4	(2.1–2.6)	32.5	(25.9–39.1)

* Weighted sample size.
† Per 100 women.
§ 3-year average.
¶ Confidence interval.
** p<0.0001; t-test for trend.
†† p=0.0848; linear regression test for trend.
§§ p=0.2742; linear regression test for trend.
¶¶ Age-adjusted to the 2000 U.S. standard population. Numbers for other racial/ethnic groups were too small for meaningful analysis.

TABLE 2. Number* and rate† of major cardiovascular disease (CVD) hospital discharges among women with and without diabetes, by age and race/ethnicity — Nationwide Inpatient Sample and National Health Interview Survey, United States, 1997

Characteristic	Diabetes			No diabetes			Rate ratio		Rate difference	
	No.	Rate	(95% CI§)	No.	Rate	(95% CI)		(95% CI)		(95% CI)
Age group (yrs)										
18–44	19,735	22.9	(18.4– 27.4)	103,948	1.9	(1.8– 2.1)	11.8	(9.4–14.3)	20.9	(16.5– 25.4)
45–64	201,816	93.1	(81.7–104.5)	389,690	14.9	(14.0– 15.8)	6.2	(5.4– 7.1)	78.2	(66.7– 89.7)
65–74	248,357	158.9	(134.6–183.2)	483,587	56.9	(52.6– 61.3)	2.8	(2.3– 3.3)	102.0	(77.4–126.6)
≥75	302,296	332.7	(278.4–387.0)¶	1,030,783	136.2	(126.4–146.0)¶	2.4	(2.0– 2.9)**	196.5	(141.3–251.7)††
Unadjusted total§§	**772,346**	**140.4**	**(127.9–152.9)**	**2,017,788**	**21.0**	**(20.0– 22.0)**	**6.7**	**(6.0– 7.4)**	**119.4**	**(106.9–131.8)**
Age-adjusted total¶¶		**81.2**	**(73.6– 88.8)**		**21.6**	**(20.4– 22.8)**	**3.8**	**(3.3– 4.2)**	**59.5**	**(51.9– 67.2)**
Race/Ethnicity¶¶										
White, non-Hispanic	443,898	65.2	(57.4– 73.0)	1,340,419	16.9	(15.6– 18.3)	3.9	(3.3– 4.4)	48.3	(40.3– 56.3)
Black, non-Hispanic	109,559	69.7	(53.8– 85.6)	169,399	21.7	(17.7– 25.7)	3.2	(2.3– 4.2)	48.0	(31.7– 64.4)
Hispanic	46,127	57.0	(37.0– 77.0)	71,037	16.1	(10.7– 21.5)	3.5	(1.8– 5.3)	41.0	(20.2– 61.7)

* Weighted sample size.
† Per 1,000 women.
§ Confidence interval.
¶ p<0.0001; t-test for trend.
** p=0.0848; linear regression test for trend.
†† p=0.2742; linear regression test for trend.
§§ Includes missing ages.
¶¶ Age-adjusted to the 2000 U.S. standard population. Numbers for other racial/ethnic groups were too small for meaningful analysis.

Major Cardiovascular Disease — Continued

increased physical activity, smoking cessation/prevention, and improved diet (*7*). Primary prevention of diabetes, a risk factor for major CVD, also can prevent major CVD. The Diabetes Prevention Program, a clinical trial examining the effect of intensive lifestyle intervention on the occurrence of type 2 diabetes in high-risk populations, concluded that improved diet, weight loss, and increased physical activity prevented or delayed the onset of diabetes among adults with impaired glucose tolerance (*8*).

Despite the efficacy of prevention strategies for major CVD, a large proportion of persons with diabetes have uncontrolled blood pressure (*9*), dyslipidemia (*9*), and hyperglycemia (*9*) and do not take aspirin (*5*). Additional research is needed to learn how to improve the process and outcomes of care among persons with diabetes. A concerted effort among health-care providers, public health officials, members of community-based organizations, and patients and their families will be necessary to reduce major CVD among persons with diabetes.

The high rate of major CVD among women with diabetes of all ages indicates that strategies for CVD risk reduction should be offered to all women with diabetes. Rate differences in hospital discharges increased with age, indicating that the effects of successful CVD prevention efforts should increase with age for women with diabetes.

The findings in this study are subject to at least six limitations. First, NHIS data on history of diabetes and major CVD are self-reported; however, studies comparing self-reported with physician-reported medical history data have found no difference in the prevalence of diabetes, and self-reported prevalence rates for CVD and hypertension were only slightly higher than physician-reported rates (*10*). Second, because NHIS excludes the institutionalized population, the number of persons with major CVD and diabetes is underestimated. Third, because NIS data represent hospital discharges and not individual persons, patients with multiple CVD hospitalizations within 1 year were counted multiple times; this might have resulted in an overestimation of hospital discharge rates. Fourth, by not including data from long-term and federal hospitals, NIS underestimates major CVD hospitalizations. Fifth, race/ethnicity is missing for approximately 20% of hospital discharges in NIS; four states that contribute to NIS provided no information on race/ethnicity, and one state provided race/ethnicity for approximately 25% of discharges. Therefore, race/ethnicity rates might be underreported and might be biased if disease patterns vary differentially across the reporting and nonreporting states. Finally, because the NIS sample comprised only 22 states, these data might be biased and might differ from estimates of the National Hospital Discharge Sample . However, in 1997, both data sources produced similar estimates of discharges with diabetes as the primary diagnosis (AHRQ, unpublished data, 2000).

CDC has published *Diabetes and Women's Health Across the Life Stages: A Public Health Perspective* that addresses the need for more research to gain a better understanding of the excess risk for major CVD among women with diabetes and to identify modifiable behavior and other determinants that can be used to develop effective interventions. The National Institutes of Health and CDC also have implemented the National Diabetes Education Program that includes public and private partners in the treatment and outcome of persons with diabetes; this program promotes early diagnosis to reduce morbidity and mortality associated with diabetes. CDC supports diabetes control programs in every state and, in 1998, initiated support for cardiovascular health promotion, disease prevention, and control programs. Since 1999, CDC has supported REACH 2010 (Racial and Ethnic Approaches to Community Health) to eliminate racial/ethnic disparities in numerous health areas, including diabetes and CVD. Additional information on diabetes is available at <http://www.cdc.gov/Diabetes>.

Major Cardiovascular Disease — Continued

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Hospital Discharge Rates for Nontraumatic Lower Extremity Amputation by Diabetes Status — United States, 1997

Lower extremity amputation (LEA) is a costly and disabling procedure that disproportionately affects persons with diabetes (*1,2*). One of the national health objectives for 2000 was to reduce the LEA rate from a 1991 baseline of approximately eight per 1,000 persons with diabetes to a target of approximately five per 1,000 persons with diabetes. Review of 1996 data indicated an LEA rate of approximately 11. To estimate the national rates of hospital discharges for LEA among persons with and without diabetes and to assess the excess risk for LEA among persons with diabetes, CDC and the Agency for Healthcare Research and Quality (AHRQ) analyzed data from the 1997 Nationwide Inpatient Sample (NIS) and the 1997 National Health Interview Survey (NHIS). This report summarizes the findings of the analysis, which indicated that the age-adjusted rates of hospital discharges among persons with LEA who had diabetes were 28 times that of those without diabetes. This higher rate underscores the need to increase efforts to prevent risk factors (e.g., peripheral vascular disease, neuropathy, and infection) that result in LEA among persons with diabetes.

Nontraumatic Lower Extremity Amputation — Continued

Hospital discharges were estimated from NIS, a stratified probability sample of hospitals in 22 states. Discharges from these states represented approximately 60% of all discharges in the United States. Sample data were weighted using the American Hospital Association Annual Survey of Hospitals to approximate discharges from all U.S. acute-care community hospitals. LEA discharges were defined using *International Classification of Disease, Ninth Revision, Clinical Modification* (*ICD-9-CM*) codes 84.10–84.19 (traumatic LEA codes 895–897 were excluded). Diabetes-related LEA discharges were identified as discharges that included *ICD-9-CM* code 250 as one of the listed discharge diagnoses. LEA hospital discharge rates were calculated for populations with and without diabetes. Estimates of the number of persons with and without diabetes were obtained from the 1997 NHIS, an ongoing, nationally representative survey providing information about the health of the noninstitutionalized U.S. civilian population (*3*). SUDAAN was used to calculate estimates and 95% confidence intervals (CIs) of NIS and NHIS data. The 2000 U.S. standard population was used to adjust LEA rates by age. The rate ratio was calculated by dividing the LEA rate for persons with diabetes by the rate for persons without diabetes. The rate difference was defined as the difference in LEA rates between the two populations. The significance of trends by age was assessed for LEA rates, rate ratios, and rate differences, and t-tests in SUDAAN were used to determine the significance of the difference in mean age by diabetes status and the age-adjusted rate differences by sex and race. Z-tests were used to assess the difference between age-adjusted rates by diabetes status among all sex and race groups.

In 1997, 131,218 hospital discharges had an LEA discharge diagnosis code; 87,720 (67%) of these were related to diabetes (Table 1). Among persons with diabetes, 66.7% of LEA hospitalizations were paid by Medicare and an additional 8.1% were paid by Medicaid. Among persons with diabetes, approximately 52% of amputations occurred at or below the foot, and among persons without diabetes, approximately 70% occurred between the ankle and the knee or higher. Patients with diabetes-related LEA hospital discharges had a mean age of 66 years (95% CI=$\pm$0.3 years), and the mean age of LEA discharges not related to diabetes was 71 years (95% CI=$\pm$0.7 years) ($p<0.0001$). LEA rates increased with age in both populations, but rates were higher in the population with diabetes. LEA rate ratios ranged from 149 (95% CI=116–182) to nine (95% CI=7–10) for persons aged $\leq$44 years and $\geq$75 years, respectively. Rate differences ranged from 3.4 to 13.8 per 1,000 persons in those aged $\leq$44 years to $\geq$75 years, respectively.

The age-adjusted LEA rate for persons with diabetes (5.5 per 1,000 persons with diabetes) was 28 (95% CI=24–31) times that of persons without diabetes (0.2 per 1,000 persons without diabetes). Regardless of diabetes status, these rates were higher for men than women ($p<0.0001$) and higher for non-Hispanic blacks than Hispanics or non-Hispanic whites ($p<0.05$) (Figure 1). Age-adjusted LEA rates were much higher for persons with diabetes for both sexes and all racial/ethnic populations ($p<0.0001$).

Reported by: Center for Organization and Delivery Studies, Agency for Healthcare Research and Quality, Rockville, Maryland. Epidemiology and Statistics Br, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate that LEAs occur at a much higher rate among persons with diabetes and that diabetes causes approximately 67% of LEAs. Among persons with diabetes, LEA rates were highest among men, non-Hispanic blacks, and the elderly. These findings indicate that LEAs might increase as the U.S. population ages and as the prevalence of diabetes increases. Because approximately 75% of LEA

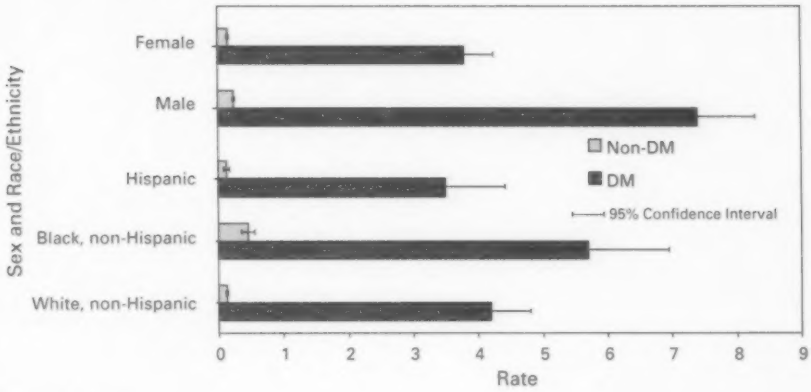
TABLE 1. Number of nontraumatic lower extremity amputation (LEA) hospital discharges, rate* of LEA for persons with and without diabetes, and LEA rate difference — National Inpatient Sample and National Health Interview Survey, United States, 1997

Characteristic	Diabetes			No diabetes			Rate difference	
	No.	Rate	(95% CI†)	No.	Rate	(95% CI)	No.	(95% CI)
Age group (yrs)								
0–44	5,844	3.4	(2.8– 4.0)	4,121	0.02	(0.02–0.03)	3.4	(2.8– 3.9)
45–64	31,352	7.5	(6.7– 8.3)	7,916	0.16	(0.14–0.17)	7.3	(6.5– 8.2)
65–74	25,362	9.8	(8.5–11.1)	9,670	0.62	(0.57–0.68)	9.2	(7.9–10.5)
≥75	25,162	15.6	(13.5–17.7)§	21,767	1.78	(1.64–1.92)§	13.8	(11.7–16.0)¶
Total	**87,720**	**8.7**	**(8.0– 9.4)**	**43,498****	**0.17**	**(0.16–0.18)**	**8.5**	**(7.8– 9.2)**
Age-adjusted††		5.4	(4.9– 6.0)		0.20	(0.19–0.21)	5.3	(4.7– 5.8)

* Per 1,000 persons.
† Confidence interval.
§ p<0.0001; t-test for trend.
¶ p=0.01; linear regression test for trend.
** Includes missing ages.
†† Age-adjusted to the 2000 U.S. standard population.

Nontraumatic Lower Extremity Amputation — Continued

FIGURE 1. Age-adjusted lower extremity amputation hospital discharge rates* for persons with diabetes mellitus (DM) and without diabetes mellitus (non-DM), by sex† and race/ethnicity§ — National Inpatient Sample and National Health Interview Survey, United States, 1997



*Per 1,000 persons.
† p<0.0001; t-test for difference.
§ p<0.05; t-test for difference among non-Hispanic blacks, non-Hispanic whites, and Hispanics. Numbers for other racial/ethnic groups were too small for meaningful analysis.

hospitalizations are paid by Medicare or Medicaid, the increase in prevalence will place a large financial burden on these public health systems.

Among persons with diabetes, LEAs result from the single or combined effects of peripheral vascular disease, peripheral neuropathy, and infection (*1,4*). Foot deformities and ulcers occurring as a consequence of neuropathy and/or peripheral vascular disease, minor trauma, and poor foot care also might contribute to LEAs (*1,5*).

The findings in this study are subject to at least five limitations. First, because NIS data represent hospital discharges and not individual persons, patients with multiple amputations within 1 year were counted multiple times; this might have resulted in an overestimation of hospital discharge rates. Second, because NIS data do not include LEAs that occurred in federal hospitals and outpatient settings, the analysis underestimates the total number of LEA discharges that occurred nationally. Third, because NHIS is representative of the noninstitutionalized civilian population, the total population with or without diabetes was underestimated. Fourth, race/ethnicity data are missing for approximately 20% of the hospital discharges in NIS data; four states contributing to NIS provided no race/ethnicity data and one state provided race/ethnicity information for approximately 25% of discharges. Therefore, race/ethnicity-specific rates are underreported and may be biased if race/ethnicity disease patterns vary across reporting and nonreporting states. Finally, because the NIS sample was constructed from only 22 states, these data might be biased and might differ from estimates of the National Hospital Discharge Sample (NHDS). However, in 1997, both data sources produced similar estimates of discharges with diabetes as the primary diagnosis (AHRQ, unpublished data, 2000).

Nontraumatic Lower Extremity Amputation — Continued

Serious foot conditions or LEA can be decreased by 44%–85% in persons with diabetes (*5*). Proper footware can lower abnormal pressure and protect the foot from calluses and ulcers, precursors of LEA (*6*). Education intervention, multidisciplinary care, and insurance coverage for therapeutic shoes are effective in reducing diabetes-related LEA (*2*). Interventions also include early detection of feet at risk through regular foot examination, knowledge of foot hygiene, nonweight-bearing exercise, and provider education on screening examinations for high-risk foot conditions (*6,7*). Good glycemic control can reduce the development of neuropathy, a high-risk condition for LEA (*8,9*).

Because no nationally representative data on lower extremity disease and its risk factors exist, in 1999, CDC and the National Heart, Lung, and Blood Institute of the National Institutes of Health added to the National Health and Nutrition Examination Survey a lower extremity disease examination component for peripheral vascular disease, peripheral neuropathy, and foot deformities, ulcers, and amputations. This component will allow national estimates of the extent of lower extremity disease and identification of its risk factors. It also will increase an understanding of racial/ethnic differences in lower extremity disease and provide information to clinicians and public health providers to develop preventive care and community-based interventions. Materials designed to make good foot care an essential part of diabetes care among health-care providers and persons with diabetes are available at <http://ndep.nih.gov/materials/pubs/feet/feet.htm>.

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Weekly Update: West Nile Virus Activity — United States, October 24–30, 2001

The following report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET and verified by states and other jurisdictions as of October 30, 2001.

During the week of October 24–30, no human cases of WNV encephalitis or meningitis were reported. During the same period, WNV infections were reported in 200 crows, 43 other birds, and eight horses. A total of 11 WNV-positive mosquito pools were reported in five states (Georgia, Kentucky, New Jersey, Ohio, and Virginia).

During 2001, a total of 37 human cases of WNV encephalitis or meningitis have been reported in Florida (ten), Maryland (six), New Jersey (six), New York (six), Connecticut (five), Pennsylvania (three), and Georgia (one); one death occurred in Georgia. Among these 37 cases, 20 (54%) were in men; the median age was 69 years (range: 36–81 years); and dates of illness onset ranged from July 13 to October 7. A total of 3,996 crows and 1,437 other birds with WNV infection were reported from 25 states and the District of Columbia (Figure 1); 159 WNV infections in other animals (all horses) were reported from 13 states (Alabama, Connecticut, Florida, Georgia, Kentucky, Louisiana, Massachusetts, Mississippi, New York, North Carolina, Pennsylvania, Tennessee, and Virginia); and 736 WNV-positive mosquito pools were reported from 15 states (Connecticut, Florida, Georgia, Illinois, Kentucky, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Virginia).

Additional information about WNV activity is available at <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and <http://cindi.usgs.gov/hazard/event/west_nile/west_nile.html>.

FIGURE 1. Areas reporting West Nile virus (WNV) activity — United States, 2001*

* As of October 30, 2001.
† Mississippi reported WNV infection in a horse but no birds.

Notice to Readers

Updated Recommendations for Antimicrobial Prophylaxis Among Asymptomatic Pregnant Women After Exposure to *Bacillus anthracis*

The antimicrobial of choice for initial prophylactic therapy among asymptomatic pregnant women exposed to *Bacillus anthracis* is ciprofloxacin, 500 mg twice a day for 60 days. In instances in which the specific *B. anthracis* strain has been shown to be penicillin-sensitive, prophylactic therapy with amoxicillin, 500 mg three times a day for 60 days, may be considered. Isolates of *B. anthracis* implicated in the current bioterrorist attacks are susceptible to penicillin in laboratory tests, but may contain penicillinase activity (*2*). Pencillins are not recommended for treatment of anthrax, where such penicillinase activity may decrease their effectiveness. However, penicillins are likely to be effective for preventing anthrax, a setting where relatively few organisms are present. Doxycycline should be used with caution in asymptomatic pregnant women and only when contraindications are indicated to the use of other appropriate antimicrobial drugs.

Pregnant women are likely to be among the increasing number of persons receiving antimicrobial prophylaxis for exposure to *B. anthracis*. Clinicians, public health officials, and women who are candidates for treatment should weigh the possible risks and benefits to the mother and fetus when choosing an antimicrobial for postexposure anthrax prophylaxis. Women who become pregnant while taking antimicrobial prophylaxis should continue the medication and consult a health-care provider or public health official to discuss these issues.

No formal clinical studies of ciprofloxacin have been performed during pregnancy. Based on limited human information, ciprofloxacin use during pregnancy is unlikely to be associated with a high risk for structural malformations in fetal development. Data on ciprofloxacin use during pregnancy from the Teratogen Information System indicate that therapeutic doses during pregnancy are unlikely to pose a substantial teratogenic risk, but data are insufficient to determine that there is no risk (*1*). Doxycycline is a tetracycline antimicrobial. Potential dangers of tetracyclines to fetal development include risk for dental staining of the primary teeth and concern about possible depressed bone growth and defective dental enamel. Rarely, hepatic necrosis has been reported in pregnant women using tetracyclines. Penicillins generally are considered safe for use during pregnancy and are not associated with an increased risk for fetal malformation. Pregnant women should be advised that congenital malformations occur in approximately 2%–3% of births, even in the absence of known teratogenic exposure.

Additional information about the treatment of anthrax infection is available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5042a1.htm>.

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Notices to Readers — Continued

Notice to Readers

Interim Recommendations for Protecting Workers from Exposure to *Bacillus anthracis* in Work Sites in which Mail is Handled or Processed

CDC has developed interim recommendations to assist personnel responsible for occupational health and safety in developing a comprehensive program to reduce potential cutaneous or inhalational exposures to *Bacillus anthracis* spores among workers in work sites in which mail is handled or processed. Such work sites include post offices, mail distribution/handling centers, bulk mail centers, air mail facilities, priority mail processing centers, public and private mail rooms, and other settings in which workers are responsible for handling and processing mail. The recommendations are based on the limited information available on methods to avoid infection and on the effectiveness of various prevention strategies. These recommendations will be updated as new informat on becomes available.

The recommendations are divided into the following hierarchical categories describing measures that should be implemented in distribution/handling centers to prevent potential exposures to *B. anthracis* spores:

- Engineering controls to prevent or capture aerosolized spores
- Administrative controls to limit the number of persons potentially exposed to spores
- Housekeeping controls to further reduce the spread of spores
- Personal protective equipment for workers to prevent cutaneous and inhalational exposure to spores

These control measures should be selected on the basis of an initial work site evaluation that focuses on determining which processes, operations, jobs, or tasks would be most likely to result in an exposure if a contaminated envelope or package enters the work site. The complete interim recommendations are available at <http://www.bt.cdc.gov>.

Notice to Readers

National Diabetes Awareness Month — November 2001

November is National Diabetes Awareness Month. During 1998 in the United States, an estimated 15.7 million persons had diabetes (*1*). From 1990 to 2000, an increase of 49% occurred in the prevalence of diagnosed diabetes and gestational diabetes in U.S. adults (*2*); however, lifestyle changes, including weight control and regular physical activity can prevent or delay the onset of type 2 diabetes, even in high-risk persons (*3*).

During November, 59 state and territorial diabetes control programs, other partners, and CDC will highlight activities that increase awareness of the Initiative on Diabetes and Women's Health and of the need for persons with diabetes to receive influenza and pneumococcal vaccines. Persons with diabetes should receive pneumococcal and annual influenza vaccinations because they are more likely than persons without diabetes to die from complications of influenza and pneumonia (*4*). In 1997, only half of adults with diabetes received an annual influenza vaccination, and one third received a pneumococcal vaccine (*5*).

Notices to Readers — Continued

CDC, the American Diabetes Association, the American Public Health Association, and the Association of State and Territorial Health Officials cosponsor the Initiative on Diabetes and Women's Health, which has three phases: a report; the *National Public Health Action Plan for Women and Diabetes*; and a national conference. CDC's recently published report, *Diabetes and Women's Health Across the Life Stages: A Public Health Perspective*, is the first major publication to address the unique and serious impact diabetes has on women throughout life and to address the public health implications of these issues (*6*). The publication presents 1) trends in risk factors for diabetes and its complications during adolescence; 2) the increased risk for offspring to develop diabetes associated with intrauterine exposure to hyperglycemia; 3) the effect of menopause on health status; and 4) the increase in poverty and disability for older women.

Additional information about diabetes is available from CDC, telephone (877) 232-3422, e-mail diabetes@cdc.gov, and from <http://www.cdc.gov/diabetes>.

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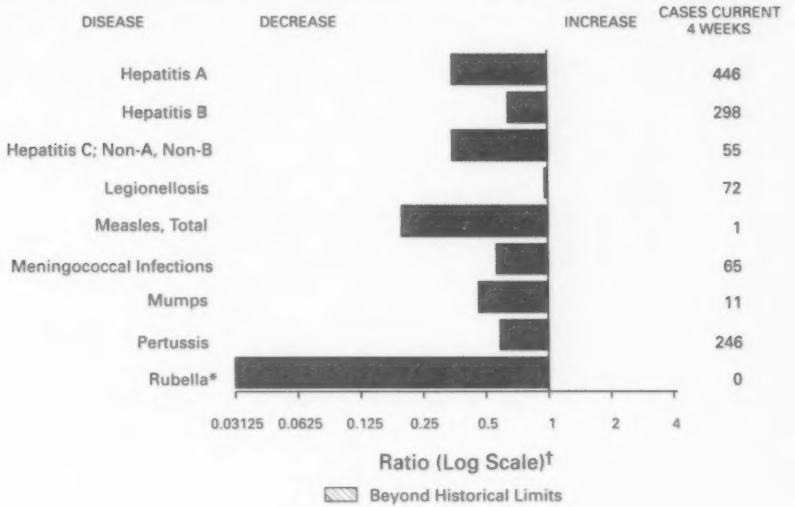
Erratum: Vol. 50, No. 42

In the article, "Update: Investigation of Bioterrorism-Related Anthrax and Interim Guidelines for Exposure Management and Antimicrobial Therapy, October 2001," on page 911 two dates were incorrect. The fourth sentence of the fourth paragraph should read "The patient was reported to CDC on *October 15*, and serologic testing at CDC was positive to *B. anthracis*." The first sentence of the sixth paragraph should read, "On *October 18*, the postal facility was closed; the New Jersey Department of Health and Senior Services recommended that postal workers at both postal facilities initiate antimicrobial prophylaxis pending further epidemiologic and environmental investigation."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending October 27, 2001, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 43 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending October 27, 2001 (43rd Week)*

	Cum. 2001		Cum. 2001
Anthrax	11	Poliomyelitis, paralytic	-
Brucellosis†	73	Psittacosis†	15
Cholera	3	Q fever†	18
Cyclosporiasis†	122	Rabies, human	1
Diphtheria	2	Rocky Mountain spotted fever (RMSF)	475
Ehrlichiosis: human granulocytic (HGE)†	171	Rubella, congenital syndrome	-
human monocytic (HME)†	71	Streptococcal disease, invasive, group A	2,938
Encephalitis: California serogroup viral†	84	Streptococcal toxic-shock syndrome†	41
eastern equine†	6	Syphilis, congenital¶	166
St. Louis†	1	Tetanus	22
western equine†	-	Toxic-shock syndrome	96
Hansen disease (leprosy)†	71	Trichinosis	21
Hantavirus pulmonary syndrome†	7	Tularemia†	90
Hemolytic uremic syndrome, postdiarrheal†	121	Typhoid fever	227
HIV infection, pediatric¶†	153	Yellow fever	-
Plague	2		

-: No reported cases.
*Incidence data for reporting year 2001 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
† Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update September 25, 2001.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 27, 2001, and October 28, 2000 (43rd Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7†			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	29,580	31,406	579,265	573,902	2,403	2,621	2,477	3,923	1,959	3,209
NEW ENGLAND	1,129	1,639	18,705	19,167	109	127	206	341	208	354
Maine	36	28	893	1,192	17	20	25	26	26	28
N.H.	31	28	1,104	909	14	21	32	31	26	34
Vt.	13	29	506	439	30	26	13	32	8	33
Mass.	602	1,049	7,747	8,148	44	33	111	154	106	161
R.I.	78	75	2,422	2,216	4	3	14	18	11	17
Conn.	369	430	6,033	6,263	-	24	11	80	31	81
MID. ATLANTIC	6,710	6,816	62,871	53,734	221	330	184	390	165	274
Upstate N.Y.	731	664	11,368	1,961	89	105	142	258	121	60
N.Y. City	3,385	3,695	24,324	21,927	73	152	11	21	10	15
N.J.	1,389	1,345	8,936	8,890	7	16	31	111	34	111
Pa.	1,205	1,112	18,243	20,956	52	57	N	N	-	88
E.N. CENTRAL	2,238	3,042	91,419	98,533	911	869	664	968	450	687
Ohio	430	430	20,222	25,947	140	239	174	240	137	204
Ind.	264	282	12,732	11,017	72	57	72	109	39	83
Ill.	992	1,568	22,501	27,604	1	109	144	180	128	145
Mich.	413	601	24,980	20,443	163	84	81	130	69	103
Wis.	139	161	10,984	13,522	535	380	193	309	77	152
W.N. CENTRAL	637	723	29,666	32,651	354	328	395	568	404	541
Minn.	108	129	5,994	6,727	137	112	151	149	186	173
Iowa	71	69	3,797	4,437	75	72	76	169	59	139
Mo.	312	349	10,826	11,104	35	27	46	98	77	90
N. Dak.	2	2	750	729	12	15	17	15	31	20
S. Dak.	22	7	1,414	1,521	6	15	37	53	40	57
Nebr.	52	53	2,175	3,067	88	78	51	58	-	46
Kans.	70	114	4,710	5,066	1	9	17	26	11	16
S. ATLANTIC	9,497	8,757	109,994	108,234	272	404	198	318	121	260
Del.	203	182	2,041	2,370	6	5	4	2	6	1
Md.	1,506	1,056	9,278	11,767	34	9	23	30	1	2
D.C.	644	570	2,533	2,696	10	13	-	1	U	U
Va.	723	574	14,965	12,815	24	16	47	61	36	57
W. Va.	61	50	1,937	1,779	2	3	10	14	8	12
N.C.	726	585	16,621	18,505	24	21	46	77	29	65
S.C.	577	639	9,374	7,954	-	-	10	21	11	16
Ga.	1,031	991	23,903	22,752	103	148	26	35	15	36
Fla.	4,026	4,110	29,342	27,596	69	189	32	77	15	71
E.S. CENTRAL	1,423	1,609	39,887	42,269	39	45	115	122	96	98
Ky.	278	160	7,415	6,638	4	5	57	39	47	31
Tenn.	456	684	11,910	12,148	12	11	35	51	36	47
Ala.	347	417	11,037	13,082	13	15	16	8	6	9
Miss.	342	348	9,525	10,401	10	14	7	24	7	11
W.S. CENTRAL	3,141	3,333	86,710	86,903	32	146	84	213	86	262
Ark.	159	158	6,043	5,547	6	11	12	54	-	37
La.	665	554	14,403	15,261	7	10	4	14	25	44
Okla.	186	294	8,591	7,826	12	17	26	18	24	16
Tex.	2,131	2,327	57,673	58,269	7	108	42	127	37	165
MOUNTAIN	1,073	1,211	33,131	32,048	193	156	248	382	127	281
Mont.	14	12	1,542	1,154	30	10	16	30	-	-
Idaho	17	19	1,542	1,513	21	21	63	64	-	38
Wyo.	3	9	676	662	6	5	5	17	1	9
Colo.	231	294	7,022	8,809	34	65	83	147	52	105
N. Mex.	103	126	4,738	4,202	22	16	13	19	9	16
Ariz.	437	386	11,974	10,589	7	10	22	44	22	35
Utah	90	113	1,512	1,851	69	25	31	48	42	68
Nev.	178	252	4,125	3,268	4	4	15	13	1	10
PACIFIC	3,732	4,276	106,882	100,363	272	216	383	621	302	452
Wash.	395	379	11,264	10,740	43	U	109	195	62	196
Oreg.	154	113	6,122	5,499	44	16	61	126	57	107
Calif.	3,112	3,670	84,121	79,092	181	200	192	257	176	135
Alaska	16	15	2,180	2,062	1	-	4	29	1	3
Hawaii	55	99	3,195	2,970	3	-	17	14	6	11
Guam	10	13	-	422	-	-	N	N	U	U
P.R.	934	1,052	2,140	U	-	-	1	6	U	U
V.I.	2	31	53	-	-	-	-	-	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	103	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

‡ Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last updated September 25, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending October 27, 2001, and October 28, 2000 (43rd Week)*

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	267,135	294,333	2,683	2,634	820	914	374	10,536	14,235
NEW ENGLAND	5,408	5,413	14	24	56	50	31	3,337	4,379
Maine	97	77	-	2	8	2	1	-	-
N.H.	154	89	-	-	10	2	4	130	60
Vt.	53	54	6	4	5	5	2	14	32
Mass.	2,445	2,229	8	13	15	16	19	654	1,094
R.I.	681	536	-	5	9	8	1	436	414
Conn.	1,978	2,428	-	-	9	17	4	2,103	2,779
MID. ATLANTIC	31,792	32,139	1,310	589	161	251	57	5,301	7,522
Upstate N.Y.	6,932	6,094	48	33	55	73	25	2,990	3,241
N.Y. City	10,238	9,554	-	-	16	41	8	2	170
N.J.	5,856	6,005	1,214	517	8	20	10	927	2,346
Pa.	8,766	10,486	48	39	82	117	14	1,382	1,765
E.N. CENTRAL	49,109	58,968	148	197	226	238	50	577	744
Ohio	11,199	15,875	5	11	109	99	13	105	56
Ind.	5,603	5,185	1	-	19	32	8	20	22
Ill.	13,874	17,360	13	19	-	28	1	21	34
Mich.	14,464	14,753	129	167	65	42	21	1	23
Wis.	3,969	5,795	-	-	33	37	7	430	609
W.N. CENTRAL	12,758	14,783	603	484	46	54	15	337	361
Minn.	1,964	2,637	9	5	9	7	-	279	267
Iowa	997	1,048	-	2	8	13	2	30	30
Mo.	6,741	7,266	582	466	19	24	8	23	45
N. Dak.	33	60	-	-	1	-	-	-	1
S. Dak.	228	253	-	-	3	2	-	-	-
Nebr.	710	1,217	3	4	5	4	1	3	3
Kans.	2,085	2,302	9	7	1	4	4	2	15
S. ATLANTIC	68,261	76,885	96	92	170	165	62	740	995
Del.	1,212	1,418	-	2	11	8	-	49	167
Md.	5,030	8,128	16	12	32	60	11	474	583
D.C.	2,292	2,163	-	3	7	5	-	10	5
Va.	8,948	8,673	-	3	20	31	11	111	133
W. Va.	554	539	9	14	N	N	5	11	28
N.C.	13,895	15,135	19	14	8	13	5	37	43
S.C.	6,293	7,091	6	2	10	4	5	5	7
Ga.	13,168	14,746	-	3	9	6	11	-	-
Fla.	16,869	18,992	46	39	73	38	14	43	29
E.S. CENTRAL	25,780	30,500	169	393	50	32	19	53	47
Ky.	2,967	2,942	8	31	11	17	5	22	11
Tenn.	8,031	9,738	57	85	25	10	8	22	28
Ala.	8,515	10,130	4	9	12	3	6	8	5
Miss.	6,267	7,690	100	268	2	2	-	1	3
W.S. CENTRAL	42,336	45,836	171	633	5	22	17	79	78
Ark.	3,646	3,257	4	8	-	-	1	-	5
La.	9,857	11,248	83	379	2	7	-	1	7
Okla.	3,897	3,450	3	8	3	3	2	-	-
Tex.	24,936	27,881	81	238	-	12	14	78	66
MOUNTAIN	8,313	8,724	59	66	46	37	31	12	11
Mont.	86	39	1	4	-	1	-	-	-
Idaho	62	69	2	3	3	5	1	6	2
Wyo.	67	40	6	2	1	-	1	1	3
Colo.	2,412	2,661	19	12	13	13	7	1	-
N. Mex.	799	923	11	13	2	1	7	-	-
Ariz.	3,240	3,533	9	18	18	7	6	1	-
Utah	119	178	3	1	5	10	2	1	3
Nev.	1,528	1,281	8	13	4	-	7	2	3
PACIFIC	23,378	21,085	113	156	60	65	92	100	98
Wash.	2,499	1,911	19	28	8	15	8	8	7
Oreg.	963	790	12	25	N	N	8	8	9
Calif.	19,080	17,713	82	101	48	49	70	82	80
Alaska	347	287	-	-	-	-	-	2	2
Hawaii	489	384	-	2	4	1	6	N	N
Guam	-	45	-	3	-	-	-	-	-
P.R.	496	421	1	1	2	1	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	10	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending October 27, 2001, and October 28, 2000 (43rd Week)*

Reporting Area	Malaria		Rabies, Animal		Salmonellosis†			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	955	1,237	5,559	5,961	30,139	32,734	24,463	27,634
NEW ENGLAND	64	65	620	701	2,076	1,910	1,963	1,945
Maine	4	6	60	116	158	108	137	88
N.H.	2	1	20	21	154	123	139	130
Vt.	1	2	56	53	71	100	63	96
Mass.	27	30	223	231	1,154	1,100	1,054	1,106
R.I.	7	8	56	50	113	121	154	132
Conn.	23	18	203	230	426	358	416	393
MID. ATLANTIC	256	327	1,040	1,116	3,484	4,261	3,212	4,535
Upstate N.Y.	58	63	677	703	1,027	1,031	1,043	1,124
N.Y. City	130	187	24	13	861	1,046	1,091	1,125
N.J.	34	43	165	167	652	1,009	657	880
Pa.	34	34	174	233	944	1,175	421	1,406
E.N. CENTRAL	91	123	120	146	4,018	4,540	3,627	3,065
Ohio	20	17	42	48	1,059	1,250	1,061	1,239
Ind.	16	5	3	-	451	540	399	534
Ill.	1	59	24	22	1,099	1,325	1,049	126
Mich.	35	29	45	65	698	762	689	825
Wis.	19	13	6	11	711	663	429	341
W.N. CENTRAL	30	61	291	483	1,854	2,049	2,079	2,222
Minn.	6	27	42	77	487	465	609	597
Iowa	6	2	73	69	298	313	277	302
Mo.	11	15	38	49	529	614	811	756
N. Dak.	-	2	33	106	52	48	76	70
S. Dak.	-	1	25	86	139	84	111	93
Nebr.	2	8	4	2	125	195	-	133
Kans.	5	6	76	94	224	330	195	271
S. ATLANTIC	239	277	1,902	2,032	7,337	6,705	4,977	5,126
Del.	2	5	30	47	79	105	87	115
Md.	101	94	279	355	694	684	770	603
D.C.	13	15	-	-	72	55	U	U
Va.	44	47	399	486	1,152	849	747	811
W. Va.	1	4	123	103	113	139	124	133
N.C.	16	32	508	493	1,134	940	954	983
S.C.	6	2	103	142	768	641	627	493
Ga.	12	19	294	268	1,258	1,204	1,210	1,509
Fla.	44	59	166	138	2,067	2,088	458	479
E.S. CENTRAL	31	42	184	181	2,238	2,044	1,618	1,560
Ky.	12	17	26	19	328	329	210	225
Tenn.	11	11	96	92	546	538	663	699
Ala.	6	13	60	69	617	570	474	522
Miss.	2	1	2	1	747	607	271	114
W.S. CENTRAL	11	67	876	775	3,213	4,213	2,068	2,570
Ark.	3	3	20	20	765	618	92	503
La.	4	11	-	3	313	744	566	621
Okla.	3	8	57	51	403	335	292	261
Tex.	1	45	799	701	1,732	2,516	1,118	1,185
MOUNTAIN	48	42	217	245	1,833	2,339	1,511	2,182
Mont.	3	1	31	61	62	79	-	-
Idaho	3	3	28	9	121	103	4	96
Wyo.	-	-	20	50	52	98	43	49
Colo.	19	20	-	-	519	621	531	601
N. Mex.	3	-	14	19	250	201	205	184
Ariz.	9	7	109	88	513	612	522	648
Utah	3	5	14	10	188	426	183	424
Nev.	8	6	1	8	128	239	23	180
PACIFIC	185	233	309	282	4,086	4,673	3,408	4,429
Wash.	9	25	-	-	442	487	491	577
Oreg.	11	35	3	7	207	259	271	315
Calif.	155	163	269	249	3,084	3,669	2,335	3,297
Alaska	1	-	37	26	34	53	28	33
Hawaii	9	10	-	-	319	205	283	207
Guam	-	2	-	-	-	23	U	U
P.R.	3	5	80	67	459	572	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	11	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending October 27, 2001, and October 28, 2000 (43rd Week)*

Reporting Area	Shigellosis† NETSS Cum. 2001	Shigellosis† NETSS Cum. 2000	Shigellosis† PHLIS Cum. 2001	Shigellosis† PHLIS Cum. 2000	Syphilis (Primary & Secondary) Cum. 2001	Syphilis (Primary & Secondary) Cum. 2000	Tuberculosis Cum. 2001	Tuberculosis Cum. 2000
UNITED STATES	14,667	18,607	6,786	10,688	4,754	5,041	9,883	11,716
NEW ENGLAND	228	355	245	339	49	74	340	353
Maine	6	10	2	11	-	1	8	16
N.H.	6	6	3	8	1	2	14	17
Vt.	7	4	5	-	2	-	4	4
Mass.	177	249	170	226	27	52	198	204
R.I.	17	26	23	30	9	4	29	27
Conn.	15	60	42	64	10	15	87	85
MID. ATLANTIC	1,086	2,215	669	1,450	428	234	1,810	1,858
Upstate N.Y.	427	631	101	202	23	9	285	247
N.Y. City	293	865	319	593	228	97	869	1,002
N.J.	185	470	184	403	116	59	418	444
Pa.	181	249	65	252	61	69	238	165
E.N. CENTRAL	3,614	3,609	1,585	1,080	792	1,013	1,070	1,166
Ohio	2,492	325	1,047	270	70	64	217	239
Ind.	186	1,353	34	143	143	299	85	114
Ill.	419	1,051	288	74	239	354	500	544
Mich.	265	591	192	542	318	254	203	195
Wis.	252	289	24	51	22	42	65	74
W.N. CENTRAL	1,530	2,079	1,114	1,763	75	58	377	427
Minn.	360	680	384	768	27	15	190	132
Iowa	336	450	276	307	4	10	34	33
Mo.	279	599	185	420	21	26	109	157
N. Dak.	20	16	28	49	-	-	3	2
S. Dak.	410	7	206	4	-	-	12	16
Nebr.	63	126	-	102	5	2	29	20
Kans.	62	201	35	113	18	5	-	67
S. ATLANTIC	2,027	2,530	651	1,014	1,656	1,676	1,955	2,380
Del.	14	22	10	20	9	8	15	14
Md.	131	177	82	98	203	256	180	204
D.C.	50	67	U	U	32	34	51	26
Va.	303	394	124	319	90	114	211	215
W. Va.	8	4	8	3	4	3	26	26
N.C.	305	316	149	238	380	410	287	291
S.C.	227	112	114	82	203	191	153	229
Ga.	252	223	130	159	305	320	367	512
Fla.	737	1,215	34	95	430	340	665	863
E.S. CENTRAL	1,385	959	508	497	526	747	673	777
Ky.	646	396	264	94	40	70	102	99
Tenn.	86	314	85	347	269	447	241	298
Ala.	185	69	130	50	104	107	221	255
Miss.	468	180	29	6	113	123	109	125
W.S. CENTRAL	1,944	2,912	1,098	926	604	697	758	1,710
Ark.	497	174	155	51	31	91	127	158
La.	121	241	137	151	138	185	-	146
Okla.	66	107	17	38	57	101	119	128
Tex.	1,260	2,390	789	686	378	320	512	1,278
MOUNTAIN	806	1,019	603	741	203	199	402	428
Mont.	5	7	-	-	-	-	6	14
Idaho	34	44	-	25	1	1	8	7
Wyo.	3	5	1	3	1	1	3	2
Colo.	210	221	239	180	36	8	99	71
N. Mex.	110	134	72	98	18	15	24	36
Ariz.	331	423	236	293	131	168	178	174
Utah	48	72	47	76	8	1	32	41
Nev.	65	113	8	66	8	5	52	83
PACIFIC	2,047	2,929	313	2,878	421	343	2,498	2,617
Wash.	174	401	167	371	42	55	199	211
Oreg.	76	152	91	98	13	11	84	83
Calif.	1,734	2,337	-	2,377	356	276	2,055	2,121
Alaska	6	7	6	3	-	-	40	88
Hawaii	57	32	49	29	10	1	120	114
Guam	-	35	U	U	-	3	-	47
P.R.	8	29	U	U	234	130	76	119
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	4	U	U	U	4	U	23	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending October 27, 2001, and October 28, 2000 (43rd Week)*

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported†		Total	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	1,046	1,065	8,391	10,977	5,286	5,827	-	49	-	42	91	72
NEW ENGLAND	78	84	540	330	83	94	-	4	-	1	5	6
Maine	2	1	10	19	5	5	-	-	-	-	-	-
N.H.	4	12	16	18	14	15	-	-	-	-	-	3
Vt.	3	7	14	9	4	6	-	1	-	-	1	3
Mass.	35	37	235	121	4	13	-	2	-	1	3	-
R.I.	5	4	55	22	25	18	-	-	-	-	-	-
Conn.	29	23	210	141	31	37	-	1	-	-	1	-
MID. ATLANTIC	154	193	780	1,284	842	975	-	4	-	11	15	21
Upstate N.Y.	57	82	210	210	110	109	-	1	-	4	5	10
N.Y. City	36	52	231	443	346	476	-	2	-	1	3	10
N.J.	39	35	159	244	169	151	-	-	-	1	1	-
Pa.	20	24	180	387	217	239	-	1	-	5	6	1
E.N. CENTRAL	136	155	974	1,411	727	599	-	-	-	10	10	7
Ohio	49	47	171	227	84	93	-	-	-	3	3	2
Ind.	43	26	92	89	42	41	-	-	-	4	4	-
Ill.	10	53	373	614	124	104	-	-	-	3	3	3
Mich.	12	9	282	408	477	326	-	-	-	-	-	2
Wis.	22	20	56	73	-	35	-	-	-	-	-	-
W.N. CENTRAL	54	63	351	595	169	249	-	4	-	-	4	1
Minn.	32	34	34	165	20	34	-	2	-	-	2	1
Iowa	-	-	31	61	21	30	-	-	-	-	-	-
Mo.	13	19	97	241	90	122	-	2	-	-	2	-
N. Dak.	7	2	3	3	1	2	-	-	-	-	-	-
S. Dak.	-	1	2	1	1	1	-	-	-	-	-	-
Nebr.	1	3	30	30	19	37	U	-	U	-	-	-
Kans.	1	4	154	94	17	23	-	-	-	-	-	-
S. ATLANTIC	308	237	1,963	1,215	1,163	1,034	-	4	-	1	5	4
Del.	-	-	-	14	-	14	-	-	-	-	-	-
Md.	74	73	230	175	121	110	-	2	-	1	3	-
D.C.	-	-	43	23	11	28	-	-	-	-	-	-
Va.	25	35	110	130	145	137	-	1	-	-	1	2
W. Va.	14	8	18	53	20	12	-	-	-	-	-	-
N.C.	44	21	193	123	173	208	-	-	-	-	-	-
S.C.	6	7	65	70	28	14	-	-	-	-	-	-
Ga.	72	57	752	243	305	181	-	1	-	-	1	-
Fla.	73	36	552	384	360	330	-	-	-	-	-	2
E.S. CENTRAL	64	41	330	352	363	386	-	2	-	-	2	-
Ky.	2	12	117	46	40	64	-	2	-	-	2	-
Tenn.	34	17	129	123	195	180	-	-	-	-	-	-
Ala.	26	10	68	46	74	50	-	-	-	-	-	-
Miss.	2	2	16	137	54	92	-	-	-	-	-	-
W.S. CENTRAL	38	61	1,143	2,053	556	964	-	1	-	-	1	-
Ark.	-	2	62	121	84	87	-	-	-	-	-	-
La.	3	16	56	76	39	135	-	-	-	-	-	-
Okla.	35	41	106	224	70	134	-	-	-	-	-	-
Tex.	-	2	919	1,632	363	608	-	1	-	-	1	-
MOUNTAIN	122	102	638	768	427	447	-	1	-	1	2	12
Mont.	-	1	10	7	3	6	-	-	-	-	-	-
Idaho	1	4	53	23	11	6	-	-	-	1	1	-
Wyo.	-	1	7	4	2	3	-	-	-	-	-	-
Colo.	31	26	78	174	93	83	-	-	-	-	-	2
N. Mex.	20	20	33	65	124	121	-	-	-	-	-	-
Ariz.	54	35	342	386	128	167	-	1	-	-	1	-
Utah	6	11	63	49	26	20	-	-	-	-	-	3
Nev.	10	4	52	60	40	41	-	-	-	-	-	7
PACIFIC	92	129	1,672	2,969	956	1,079	-	29	-	18	47	21
Wash.	4	5	125	245	117	93	-	13	-	2	15	3
Oreg.	17	29	88	154	91	97	-	4	-	-	4	-
Calif.	43	33	1,462	2,544	723	868	-	10	-	11	21	14
Alaska	6	40	14	13	9	10	-	-	-	-	-	1
Hawaii	22	22	3	13	16	11	-	2	-	5	7	3
Guam	-	1	-	1	-	9	U	-	U	-	-	-
P.R.	1	4	95	218	139	245	-	-	-	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	28	U	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

† For imported measles, cases include only those resulting from importation from other countries.

§ Of 223 cases among children aged <5 years, serotype was reported for 116, and of those, 19 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending October 27, 2001, and October 28, 2000 (43rd Week)*

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	1,748	1,841	3	182	276	35	3,794	5,679	-	20	146
NEW ENGLAND	98	113	-	-	4	1	334	1,451	-	-	12
Maine	4	8	-	-	-	-	21	41	-	-	-
N.H.	13	11	-	-	-	1	27	102	-	-	2
Vt.	5	3	-	-	-	-	27	209	-	-	-
Mass.	50	65	-	-	1	-	237	1,041	-	-	8
R.I.	4	9	-	-	1	-	5	16	-	-	1
Conn.	22	17	-	-	2	-	17	42	-	-	1
MID. ATLANTIC	183	210	-	19	23	4	251	572	-	5	9
Upstate N.Y.	52	64	-	3	10	4	125	287	-	1	1
N.Y. City	34	38	-	9	6	-	38	75	-	3	8
N.J.	43	42	-	3	3	-	18	30	-	1	-
Pa.	54	66	-	4	4	-	70	180	-	-	-
E.N. CENTRAL	224	331	-	17	20	8	535	661	-	3	1
Ohio	67	78	-	1	7	-	203	288	-	-	-
Ind.	36	36	-	2	1	4	78	86	-	1	-
Ill.	22	76	-	11	6	3	65	97	-	2	1
Mich.	57	102	-	3	5	1	122	80	-	-	-
Wis.	42	39	-	-	1	-	67	110	-	-	-
W.N. CENTRAL	125	131	-	7	17	2	245	477	-	3	1
Minn.	18	20	-	3	-	-	105	284	-	-	-
Iowa	26	30	-	-	7	-	20	46	-	1	-
Mo.	44	61	-	-	4	2	89	74	-	1	-
N. Dak.	6	2	-	-	1	-	4	6	-	-	-
S. Dak.	5	5	-	-	-	-	4	7	-	-	-
Nebr.	12	6	U	1	2	U	4	24	U	-	1
Kans.	14	7	-	3	3	-	19	36	-	1	-
S. ATLANTIC	326	256	-	34	40	-	204	430	-	6	94
Del.	4	1	-	-	-	-	-	8	-	1	1
Md.	37	26	-	6	9	-	31	110	-	-	-
D.C.	-	-	-	-	-	-	1	3	-	-	-
Va.	35	37	-	6	9	-	36	97	-	-	-
W. Va.	12	12	-	-	-	-	2	1	-	-	-
N.C.	60	34	-	5	6	-	63	94	-	-	64
S.C.	31	21	-	5	10	-	31	26	-	2	27
Ga.	40	43	-	7	2	-	14	36	-	-	-
Fla.	107	82	-	5	4	-	26	55	-	3	2
E.S. CENTRAL	119	122	2	8	5	1	128	103	-	-	6
Ky.	20	25	2	3	1	-	34	52	-	-	1
Tenn.	56	51	-	1	2	-	56	31	-	-	1
Ala.	30	33	-	-	2	1	35	17	-	-	4
Miss.	13	13	-	4	-	-	4	3	-	-	-
W.S. CENTRAL	195	194	-	10	29	8	394	317	-	1	8
Ark.	18	12	-	1	1	5	33	34	-	-	1
La.	59	42	-	2	5	-	2	19	-	-	1
Okla.	27	26	-	-	-	3	17	21	-	-	-
Tex.	91	114	-	7	23	-	342	243	-	1	6
MOUNTAIN	83	77	-	11	18	6	1,146	656	-	1	2
Mont.	4	4	-	1	1	-	31	35	-	-	-
Idaho	7	7	-	1	-	1	169	57	-	-	-
Wyo.	5	-	-	1	1	-	1	4	-	-	-
Colo.	29	27	-	1	-	5	232	384	-	1	1
N. Mex.	12	7	-	2	1	-	129	83	-	-	-
Ariz.	13	22	-	1	4	-	498	63	-	-	1
Utah	7	7	-	1	5	-	71	18	-	-	-
Nev.	6	3	-	3	6	-	15	12	-	-	-
PACIFIC	395	407	1	76	120	5	557	1,012	-	1	13
Wash.	59	49	-	1	9	4	136	340	-	-	7
Oreg.	38	55	N	N	N	1	45	104	-	-	-
Calif.	284	287	1	38	83	-	338	511	-	-	6
Alaska	2	8	-	1	8	-	7	20	-	-	-
Hawaii	12	8	-	36	20	-	31	37	-	1	-
Guam	-	-	U	-	14	U	-	3	U	-	1
P.R.	4	9	-	-	-	-	2	7	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 are provisional and cumulative (year-to-date). Incidence data for reporting year 2000 are finalized and cumulative (year-to-date).

TABLE IV. Deaths in 122 U.S. cities,* week ending October 27, 2001 (43rd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	544	396	93	41	10	3	38
Boston, Mass.	160	105	30	20	3	2	9
Bridgeport, Conn.	36	30	4	2	-	-	-
Cambridge, Mass.	22	18	3	1	-	-	2
Fall River, Mass.	22	17	3	1	1	-	-
Hartford, Conn.	43	27	10	3	3	-	2
Lowell, Mass.	21	18	2	-	-	1	3
Lynn, Mass.	15	12	2	1	-	-	1
New Bedford, Mass.	24	18	6	-	-	-	5
New Haven, Conn.	31	22	4	4	1	-	2
Providence, R.I.	61	50	8	3	-	-	-
Somerville, Mass.	6	3	1	1	-	-	1
Springfield, Mass.	27	20	4	3	-	-	2
Waterbury, Conn.	16	11	4	-	1	-	1
Worcester, Mass.	60	45	12	2	1	-	10
MID. ATLANTIC	2,445	1,383	550	434	53	22	108
Albany, N.Y.	55	40	9	4	1	1	4
Allentown, Pa.	24	22	2	-	-	-	2
Buffalo, N.Y.	88	56	22	8	2	-	9
Camden, N.J.	26	17	3	3	1	2	1
Elizabeth, N.J.	17	12	4	1	-	-	-
Erie, Pa.§	37	28	5	2	2	-	2
Jersey City, N.J.	51	42	7	1	1	-	-
New York City, N.Y.	1,493	679	381	386	32	15	40
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	33	19	11	1	1	1	2
Philadelphia, Pa.	247	167	59	10	8	-	8
Pittsburgh, Pa.§	35	27	5	2	1	-	1
Reading, Pa.	15	13	1	1	-	-	1
Rochester, N.Y.	145	121	18	6	-	-	16
Schenectady, N.Y.	27	20	5	2	-	-	5
Scranton, Pa.§	32	25	5	1	-	1	2
Syracuse, N.Y.	69	52	9	5	2	1	9
Trenton, N.J.	23	17	3	1	1	1	3
Utica, N.Y.	28	26	1	-	1	-	3
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,826	1,220	394	118	46	48	149
Akron, Ohio	56	40	13	2	-	1	7
Canton, Ohio	46	36	8	-	-	2	4
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	148	93	31	11	4	9	14
Cleveland, Ohio	138	91	32	9	2	4	6
Columbus, Ohio	238	152	55	19	5	7	20
Dayton, Ohio	126	80	32	12	1	1	13
Detroit, Mich.	197	106	57	19	10	5	10
Evansville, Ind.	57	45	11	-	-	1	4
Fort Wayne, Ind.	78	54	16	4	3	1	9
Gary, Ind.	10	4	3	1	2	-	1
Grand Rapids, Mich.	53	37	9	4	2	1	6
Indianapolis, Ind.	199	136	36	12	9	6	11
Lansing, Mich.	35	28	5	1	1	-	5
Milwaukee, Wis.	140	103	25	6	1	5	10
Peoria, Ill.	42	28	9	4	-	1	3
Rockford, Ill.	58	38	13	5	1	1	8
South Bend, Ind.	52	35	11	3	1	2	4
Toledo, Ohio	97	72	20	3	2	-	13
Youngstown, Ohio	56	42	8	3	2	1	1
W.N. CENTRAL	874	619	159	46	28	22	46
Des Moines, Iowa	124	96	15	7	4	2	12
Duluth, Minn.	40	37	3	-	-	-	4
Kansas City, Kans.	53	34	16	2	1	-	2
Kansas City, Mo.	104	64	25	5	8	2	4
Lincoln, Nebr.	35	23	8	1	2	1	-
Minneapolis, Minn.	156	119	25	7	3	2	10
Omaha, Nebr.	73	47	12	7	2	5	7
St. Louis, Mo.	92	53	21	8	4	6	-
St. Paul, Minn.	85	68	12	3	1	1	2
Wichita, Kans.	112	78	22	6	3	3	5
S. ATLANTIC	1,217	742	284	119	36	36	87
Atlanta, Ga.	149	83	41	17	6	2	6
Baltimore, Md.	259	154	65	30	5	5	22
Charlotte, N.C.	85	45	18	14	-	8	9
Jacksonville, Fla.	149	97	38	7	4	3	14
Miami, Fla.	75	48	14	6	6	1	7
Norfolk, Va.	52	29	8	7	4	4	2
Richmond, Va.	70	35	20	8	5	2	2
Savannah, Ga.	42	28	10	2	-	2	9
St. Petersburg, Fla.	59	42	8	4	2	3	2
Tampa, Fla.	157	116	25	13	1	2	8
Washington, D.C.	100	45	37	11	3	4	6
Wilmington, Del.	20	20	-	-	-	-	-
E.S. CENTRAL	734	491	163	46	17	17	37
Birmingham, Ala.	151	94	41	10	4	1	5
Chattanooga, Tenn.	69	45	19	2	-	3	2
Knoxville, Tenn.	94	64	19	7	3	1	3
Lexington, Ky.	U	U	U	U	U	U	U
Memphis, Tenn.	163	110	34	9	4	6	13
Mobile, Ala.	96	65	19	7	3	2	3
Montgomery, Ala.	40	28	8	2	1	1	3
Nashville, Tenn.	121	85	23	8	2	3	8
W.S. CENTRAL	1,419	909	297	118	55	40	102
Austin, Tex.	94	59	17	6	11	1	2
Baton Rouge, La.	10	6	2	1	-	1	-
Corpus Christi, Tex.	60	37	16	2	3	2	7
Dallas, Tex.	208	131	40	19	4	14	21
El Paso, Tex.	85	54	18	10	3	-	4
Ft. Worth, Tex.	116	71	28	10	5	2	1
Houston, Tex.	343	211	72	38	11	11	27
Little Rock, Ark.	62	44	14	1	2	1	7
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	253	159	57	18	14	5	15
Shreveport, La.	56	40	11	3	-	2	6
Tulsa, Okla.	132	97	22	10	2	1	12
MOUNTAIN	1,005	687	183	71	44	20	60
Albuquerque, N.M.	114	81	23	4	6	-	7
Boise, Idaho	36	28	5	1	2	-	-
Colo. Springs, Colo.	56	39	8	4	4	1	3
Denver, Colo.	101	56	18	11	11	5	6
Las Vegas, Nev.	191	129	42	11	6	3	8
Ogden, Utah	20	15	4	1	-	-	1
Phoenix, Ariz.	159	95	31	21	4	8	13
Pueblo, Colo.	35	29	6	-	-	-	-
Salt Lake City, Utah	123	89	21	7	5	1	13
Tucson, Ariz.	170	126	25	11	6	2	9
PACIFIC	1,687	1,168	345	103	36	35	134
Berkeley, Calif.	15	11	4	-	-	-	1
Fresno, Calif.	103	77	19	4	2	1	6
Glendale, Calif.	18	12	5	1	-	-	-
Honolulu, Hawaii	84	59	16	6	2	1	8
Long Beach, Calif.	65	44	16	4	1	-	9
Los Angeles, Calif.	322	212	68	23	11	8	16
Pasadena, Calif.	33	24	5	3	1	-	5
Portland, Oreg.	111	74	22	3	6	6	6
Sacramento, Calif.	151	100	38	6	4	3	16
San Diego, Calif.	175	121	33	14	1	6	16
San Francisco, Calif.	106	75	21	9	-	1	16
San Jose, Calif.	161	104	38	14	2	3	15
Santa Cruz, Calif.	22	17	4	1	-	-	2
Seattle, Wash.	128	88	26	9	5	-	7
Spokane, Wash.	72	62	6	1	1	2	5
Tacoma, Wash.	121	88	24	5	-	4	6
TOTAL	11,751¶	7,615	2,468	1,095	325	243	761

U: Unavailable. -:No reported cases.

* Mortality data in this table are reported voluntarily from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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